Ohio Department of Job and Family Services
Cincinnati Recreation Commission

REQUEST FOR ADMINISTRATION OF MEDICATION

This form is valid for no longer than twelve (12) months. One form must be used for each medication.

Box 1 – The following section must **always** be completed by the parent/guardian.

Check all that apply:

- ❑ Prescription medication
- ❑ Nonprescription medication
- ❑ Refrigeration required
- ❑ Topical product or lotion
- ❑ Food supplement
- ❑ Modified diet

Complete all of the following information:

Name of child: _____ Date of birth: _____ Weight: _____

Name of medication: _____ Exact dosage: _____

To be administered at the following times: _____

For the following period of time: _____

Parent/Guardian signature: _____ Date: _____

Box 2 – The following section must be completed by a **licensed physician, a licensed dentist or an advance practice nurse** when:

1. A physician's instruction is needed for a nonprescription medication (e.g. child is underage or underweight per the label instructions); or
2. It is a sample medication without a prescription label; or
3. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period or is a topical product or lotion that is being used for a skin ailment and is to be given no longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated); or
5. The medication contains codeine or aspirin.

_____ is under my care and should receive _____
(name of child) (name of medication, vitamin, diet)

as follows: _____
(include dosage and instructions)

Possible side effects to watch for are: _____

Expiration date: _____
(may not exceed 12 months from the date of this request for medications or food supplements)

_____ _____ _____
Signature of physician, dentist or advance practice nurse | Date of signature | Phone number

This form must be used by child care centers and type A homes to meet the requirement of rules 5101:2-12-31 and 51-1:2-13-31.

Box 3 – The section below must be completed by the **center or type A home staff** and each administration of medication must be documented. **All** dosages must be recorded on the reverse side of this form.

_____ was given	_____ in the amount of	_____
(name of child)	(name of medication, vitamin or diet)	(dosage)

Date and Time of Dosage	Dosage Amount	Signature of Designated Person Administering Medication

To Be Completed By Parent/Guardian

I hereby request and give permission to the Cincinnati Recreation Commission's staff to administer the above listed medication(s), vitamin(s), or special diet to my child. I do hereby fully release, discharge and agree to indemnify, defend and hold harmless the City of Cincinnati and the Public Recreation Commission, their agents, employees and volunteers from any and all claims resulting from injuries, damages and losses sustained by my child or arising out of, connected with, or in any way associated with the administration of any medications. I hereby execute this release on behalf of the participant named above, and represent and warrant that I am a parent or guardian authorized to execute this release on behalf of the participant named above.

Signature of Parent/Guardian: _____ Date: _____

This form must be used by child care centers and type A homes to meet the requirement of rules 5101:2-12-31 and 51-1:2-13-31.